Workplace Accommodation Request Form - Disability Instructions to Employee:

- Before completing this form, please review the Sheridan Workplace Accommodation Policy and Workplace Accommodation Procedure (Employee) documents. If you are unsure whether your circumstances fall under the Sheridan Workplace Accommodation Policy, consult with your Manager or Human Resources Business Partner.

- To initiate the accommodation process, please provide information in the form below. If your request applies to a Human Rights ground (as defined in the Code), other than disability, please complete the Sheridan Workplace Accommodation Request Form (General).

- Please answer each question and submit the completed form to your Manager, with a copy sent to your Human Resources Business Partner.

Instructions to Manager:

Please contact your Human Resources Business Partner to discuss this request.

Please note: Please advise us in advance if there are any disability related accommodation needs we should be aware of to ensure the Workplace Accommodation process is accessible to you (i.e.: American Sign Language interpretation, documents in an alternate format, accessible meeting location, etc.)

1. Employee information

Employee Name:	**Extension:**
Email:	**Campus Location:**
Position/Title:	☐ **Davis** ☐ **HMC**
Faculty/Department:	☐ **Trafalgar**
Manager:	

2. Do you have a medical condition/disabilityfor which you are requesting workplace accommodation?

YES ☐
NO ☐

3. Is the medical condition/disability related to a workplace injury?
Have you been assessed/treated by a medical/health practitioner for the medical condition/disability?

YES ☐
NO ☐

4. Is there supporting medical information from a medical/health practitioner attached to this request form?

YES ☐
NO ☐

If YES, please send supporting medical information to:
workplaceabilities@sheridancollege.ca
**Do not attach documentation to this Request Form*

5. Please indicate the duration for which the accommodation is requested, if known:

6. Please list the medical restrictions/functional limitations arising from the medical condition/disability:

7. Please explain how the medical restrictions/functional limitations affect your ability to do your job:

8. Do your medical restrictions/functional limitations create any special concerns for you in emergency situations, such as fires, lockdowns or similar situations?

If yes, Human Resources will initiate an individualized plan with the Emergency Manager**.**

YES ☐ If yes, how:
NO ☐

Employee's Signature: _____

Date Submitted (mm/dd/yy): _____